

## REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

File Number: \_\_\_\_\_

You have the right to request the Department of Health Services (DHS) to restrict the use and disclosure of your Medi-Cal information to carry out treatment, payment or operations. You also have the right to request DHS not to disclose Medi-Cal information to a family member, relative, or friend involved with your care or payment for your health care. DHS may not be able to agree with your request. This form must be accompanied by a photocopy of a form of identification and documentation of your address. Mail this completed form to:

Department of Health Services  
EDS Communications  
P.O. Box 526018  
Sacramento, CA 95852-6018

| INDIVIDUAL INFORMATION   |                                      |                |                          |
|--|--------------------------------------|----------------|--------------------------|
| LAST NAME:   |                                      | FIRST NAME:    | MIDDLE INITIAL:          |
| ADDRESS:   |                                      | CITY/STATE:    | ZIP CODE:                |
| BENEFICIARY ID NUMBER:   |                                      | DATE OF BIRTH: |                          |
| DAYTIME TELEPHONE NUMBER:<br>(     )   | EVENING TELEPHONE NUMBER:<br>(     ) | EMAIL ADDRESS: | BEST HOURS TO REACH YOU: |
| CHECK ALL THAT APPLY   |                                      |                |                          |
| <input type="checkbox"/> I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES RESTRICT USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS: |                                      |                |                          |

☐ I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES RESTRICT THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS:

*[PLEASE PROVIDE THE NAMES OF ANY FAMILY MEMBERS, RELATIVES, OR OTHER IDENTIFIED PERSONS TO WHOM YOU DO NOT WANT DHS TO DISCLOSE INFORMATION.]*

### IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE: \_\_\_\_\_ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER: \_\_\_\_\_

I UNDERSTAND THE DEPARTMENT OF HEALTH SERVICES MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

BENEFICIARY SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.)

NOTARIZED BY: \_\_\_\_\_ ON \_\_\_\_\_ (DATE)

NOTARY PUBLIC NUMBER: \_\_\_\_\_

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION \_\_\_\_\_ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)